Senate File 61 - Introduced

SENATE FILE 61
BY MATHIS and RAGAN

A BILL FOR

- 1 An Act relating to Medicaid program improvements, providing an
- 2 appropriation, and including effective date provisions.
- 3 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

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Τ	DIVISION I
2	MEDICAID LONG-TERM SERVICES AND SUPPORTS POPULATION MEMBERS -
3	PROVISION OF CONFLICT-FREE SERVICES
4	Section 1. MEDICAID LONG-TERM SERVICES AND SUPPORTS
5	POPULATION MEMBERS - PROVISION OF CONFLICT-FREE SERVICES. The
6	department of human services shall adopt rules pursuant to
7	chapter 17A to ensure that services are provided under the
8	Medicaid program to members of the long-term services and
9	supports population in a conflict-free manner. Specifically,
L O	case management services shall be provided by independent
L1	providers and supports intensity scale assessments shall be
L 2	performed by independent assessors.
L3	DIVISION II
L 4	MEDICAID WORKFORCE PROGRAM
L 5	Sec. 2. WORKFORCE RECRUITMENT, RETENTION, AND TRAINING
L 6	PROGRAMS. The department of human services shall contractually
L 7	require any managed care organization with whom the department
L8	contracts under the Medicaid program to collaborate with
L 9	the department and stakeholders to develop and administer a
20	workforce recruitment, retention, and training program to
21	provide adequate access to appropriate services, including
22	but not limited to services to older Iowans. The department
23	shall ensure that any program developed is administered in a
24	coordinated and collaborative manner across all contracting
25	managed care organizations and shall require the managed care
26	organizations to submit quarterly progress and outcomes reports
27	to the department.
28	DIVISION III
29	PROVIDER APPEALS PROCESS — EXTERNAL REVIEW
30	Sec. 3. MEDICAID MANAGED CARE ORGANIZATION APPEALS PROCESS
31	- EXTERNAL REVIEW.
32	1. a. A Medicaid managed care organization under contract
33	with the state shall include in any written response to
3 4	a Medicaid provider under contract with the managed care
35	organization that reflects a final adverse determination of the

- 1 managed care organization's internal appeal process relative to
- 2 an appeal filed by the Medicaid provider, all of the following:
- 3 (1) A statement that the Medicaid provider's internal
- 4 appeal rights within the managed care organization have been
- 5 exhausted.
- 6 (2) A statement that the Medicaid provider is entitled to
- 7 an external independent third-party review pursuant to this
- 8 section.
- 9 (3) The requirements for requesting an external independent
- 10 third-party review.
- 11 b. If a managed care organization's written response does
- 12 not comply with the requirements of paragraph "a", the managed
- 13 care organization shall pay to the affected Medicaid provider a
- 14 penalty not to exceed one thousand dollars.
- 15 2. a. A Medicaid provider who has been denied the provision
- 16 of a service to a Medicaid member or a claim for reimbursement
- 17 for a service rendered to a Medicaid member, and who has
- 18 exhausted the internal appeal process of a managed care
- 19 organization, shall be entitled to an external independent
- 20 third-party review of the managed care organization's final
- 21 adverse determination.
- 22 b. To request an external independent third-party review of
- 23 a final adverse determination by a managed care organization,
- 24 an aggrieved Medicaid provider shall submit a written request
- 25 for such review to the managed care organization within sixty
- 26 calendar days of receiving the final adverse determination.
- 27 c. A Medicaid provider's request for an external
- 28 independent third-party review shall include all of the
- 29 following:
- 30 (1) Identification of each specific issue and dispute
- 31 directly related to the final adverse determination issued by
- 32 the managed care organization.
- 33 (2) A statement of the basis upon which the Medicaid
- 34 provider believes the managed care organization's determination
- 35 to be erroneous.

- 1 (3) The Medicaid provider's designated contact information,
- 2 including name, mailing address, phone number, fax number, and
- 3 email address.
- 4 3. a. Within five business days of receiving a Medicaid
- 5 provider's request for an external independent third-party
- 6 review pursuant to this subsection, the managed care
- 7 organization shall do all of the following:
- 8 (1) Confirm to the Medicaid provider's designated contact,
- 9 in writing, that the managed care organization has received the
- 10 request for review.
- 11 (2) Notify the department of the Medicaid provider's
- 12 request for review.
- 13 (3) Notify the affected Medicaid member of the Medicaid
- 14 provider's request for review, if the review is related to the
- 15 denial of a service.
- 16 b. If the managed care organization fails to satisfy the
- 17 requirements of this subsection, the Medicaid provider shall
- 18 automatically prevail in the review.
- 19 4. a. Within fifteen calendar days of receiving a Medicaid
- 20 provider's request for an external independent third-party
- 21 review, the managed care organization shall do all of the
- 22 following:
- 23 (1) Submit to the department all documentation submitted
- 24 by the Medicaid provider in the course of the managed care
- 25 organization's internal appeal process.
- 26 (2) Provide the managed care organization's designated
- 27 contact information, including name, mailing address, phone
- 28 number, fax number, and email address.
- 29 b. If a managed care organization fails to satisfy the
- 30 requirements of this subsection, the Medicaid provider shall
- 31 automatically prevail in the review.
- 32 5. A request for an external independent third-party review
- 33 shall automatically extend the deadline to file an appeal for a
- 34 contested case hearing under chapter 17A, pending the outcome
- 35 of the external independent third-party review, until thirty

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- 1 calendar days following receipt of the review decision by the
- 2 Medicaid provider.
- 3 6. Upon receiving notification of a request for an external
- 4 independent third-party review, the department shall do all of
- 5 the following:
- 6 a. Assign the review to an external independent third-party
- 7 reviewer.
- 8 b. Notify the managed care organization of the identity of
- 9 the external independent third-party reviewer.
- 10 c. Notify the Medicaid provider's designated contact of the
- 11 identity of the external independent third-party reviewer.
- 7. The department shall deny a request for an external
- 13 independent third-party review if the requesting Medicaid
- 14 provider fails to exhaust the managed care organization's
- 15 internal appeal process or fails to submit a timely request for
- 16 an external independent third-party review pursuant to this
- 17 section.
- 18 8. a. Multiple appeals through the external independent
- 19 third-party review process regarding the same Medicaid member,
- 20 a common question of fact, or the interpretation of common
- 21 applicable regulations or reimbursement requirements may
- 22 be combined and determined in one action upon request of a
- 23 party in accordance with rules and regulations adopted by the
- 24 department.
- 25 b. The Medicaid provider that initiated a request for
- 26 an external independent third-party review, or one or more
- 27 other Medicaid providers, may add claims to such an existing
- 28 external independent third-party review request following the
- 29 exhaustion of any applicable managed care organization internal
- 30 appeal process, if the claims involve a common question of
- 31 fact or interpretation of common applicable regulations or
- 32 reimbursement requirements.
- 9. Documentation reviewed by the external independent
- 34 third-party reviewer shall be limited to documentation
- 35 submitted pursuant to subsection 4.

- 1 10. An external independent third-party reviewer shall do 2 all of the following:
- 3 a. Conduct an external independent third-party review
- 4 of any claim submitted to the reviewer pursuant to this
- 5 subsection.
- 6 b. Within thirty calendar days from receiving the
- 7 request for an external independent third-party review from
- 8 the department and the documentation submitted pursuant to
- 9 subsection 4, issue the reviewer's final decision to the
- 10 Medicaid provider's designated contact, the managed care
- 11 organization's designated contact, the department, and the
- 12 affected Medicaid member if the decision involves a denial of
- 13 service. The reviewer may extend the time to issue a final
- 14 decision by up to fourteen calendar days upon agreement of all
- 15 parties to the review.
- 16 ll. The department shall enter into a contract with an
- 17 external independent review organization that does not have a
- 18 conflict of interest with the department or any managed care
- 19 organization to conduct the external independent third-party
- 20 reviews under this section.
- 21 a. A party, including the affected Medicaid member or
- 22 Medicaid provider, may appeal a final decision of the external
- 23 independent third-party reviewer in a contested case proceeding
- 24 in accordance with chapter 17A within thirty calendar days from
- 25 receiving the final decision. A final decision in a contested
- 26 case proceeding is subject to judicial review.
- 27 b. The final decision of an external independent
- 28 third-party reviewer conducted pursuant to this section shall
- 29 also direct the nonprevailing party to pay an amount equal to
- 30 the costs of the review to the external independent third-party
- 31 reviewer. Any payment ordered pursuant to this subsection
- 32 shall be stayed pending any appeal of the review. If the
- 33 final outcome of any appeal is to reverse the decision of the
- 34 external independent third-party reviewer, the nonprevailing
- 35 party shall pay the costs of the review to the external

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- 6 of human services shall adopt rules pursuant to chapter 17A
- 7 and shall contractually require all Medicaid managed care
- 8 organizations to issue a decision in response to a member's
- 9 request for disenrollment for good cause within ten days
- 10 of the date the member submits the request to the Medicaid
- 11 managed care organization utilizing the Medicaid managed care
- 12 organization's grievance process.
- 13 DIVISION V
- 14 UNIFORM, SINGLE CREDENTIALING
- 15 Sec. 5. MEDICAID PROGRAM USE OF UNIFORM AUTHORIZATION
- 16 CRITERIA AND SINGLE CREDENTIALING VERIFICATION
- 17 ORGANIZATION. The department of human services shall
- 18 develop uniform authorization criteria for, and shall
- 19 utilize a request for proposals process to procure, a single
- 20 credentialing verification organization to be utilized by
- 21 the state in credentialing and recredentialing providers for
- 22 both the Medicaid managed care and fee-for-service payment and
- 23 delivery systems. The department shall contractually require
- 24 all Medicaid managed care organizations to apply the uniform
- 25 authorization criteria and to accept verified information from
- 26 the single credentialing verification organization procured by
- 27 the state, and shall contractually prohibit Medicaid managed
- 28 care organizations from requiring additional credentialing
- 29 information from a provider in order to participate in the
- 30 Medicaid managed care organization's provider network.
- 31 DIVISION VI
- 32 MEDICAID MANAGED CARE OMBUDSMAN PROGRAM APPROPRIATION
- 33 Sec. 6. OFFICE OF LONG-TERM CARE OMBUDSMAN MEDICAID
- 34 MANAGED CARE OMBUDSMAN.
- 35 1. There is appropriated from the general fund of the

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- 1 state to the office of long-term care ombudsman for the fiscal
- 2 year beginning July 1, 2021, and ending June 30, 2022, in
- 3 addition to any other funds appropriated from the general
- 4 fund of the state to, and in addition to any other full-time
- 5 equivalent positions authorized for, the office of long-term
- 6 care ombudsman for the same purpose, the following amount, or
- 7 so much thereof as is necessary, to be used for the purposes
- 8 designated:
- 9 For the purposes of the Medicaid managed care ombudsman
- 10 program including for salaries, support, administration,
- 11 maintenance, and miscellaneous purposes, and for not more than
- 12 the following full-time equivalent positions:
- 13 \$ 300,000
- 14 FTES 2.50
- 15 2. The funding appropriated and the full-time equivalent
- 16 positions authorized under this section are in addition to any
- 17 other funds appropriated from the general fund of the state and
- 18 actually expended, and any other full-time equivalent positions
- 19 authorized and actually filled as of July 1, 2021, for the
- 20 Medicaid managed care ombudsman program.
- 21 3. Any funds appropriated to and any full-time equivalent
- 22 positions authorized for the office of long-term care ombudsman
- 23 for the Medicaid managed care ombudsman program for the fiscal
- 24 year beginning July 1, 2021, and ending June 30, 2022, shall
- 25 be used exclusively for the Medicaid managed care ombudsman
- 26 program.
- 27 4. The additional full-time equivalent positions authorized
- 28 in this section for the Medicaid managed care ombudsman program
- 29 shall be filled no later than September 1, 2021.
- 30 5. The office of long-term care ombudsman shall include
- 31 in the Medicaid managed care ombudsman program report, on a
- 32 quarterly basis, the disposition of resources for the Medicaid
- 33 managed care ombudsman program including actual expenditures
- 34 and a full-time equivalent positions summary for the prior
- 35 quarter.

1	EXPLANATION
2 3	The inclusion of this explanation does not constitute agreement with the explanation's substance by the members of the general assembly.
4	This bill relates to the Medicaid program.
5	Division I of the bill requires the department of human
6	services (DHS) to adopt administrative rules to ensure that
7	services are provided to the Medicaid long-term services and
8	supports population in a conflict-free manner. Specifically,
9	the bill requires that case management services shall be
10	provided by independent providers and that the supports
11	intensity scale assessments are performed by independent
12	assessors.
13	Division II of the bill requires DHS to contractually
14	require any Medicaid managed care organization (MCO) to
15	collaborate with the department and stakeholders to develop and
16	administer a workforce recruitment, retention, and training
17	program to provide adequate access to appropriate services,
18	including but not limited to services to older Iowans. The
19	department shall ensure that any such program developed is
20	administered in a coordinated and collaborative manner across
21	all contracting MCOs and shall require the MCOs to submit
22	quarterly progress and outcomes reports to the department.
23	Division III of the bill establishes an external independent
24	third-party review process for Medicaid providers for the
25	review of final adverse determinations of the MCOs' internal
26	appeal processes. The division provides that a final decision
27	of an external independent third-party reviewer may be reviewed
28	in a contested case proceeding pursuant to Code chapter 17A,
29	and ultimately is subject to judicial review.
30	Division IV of the bill relates to member disenrollment for
31	good cause during the 12 months of closed enrollment between
32	open enrollment periods. Currently, a member may request
33	disenrollment for good cause initially through their MCO's
34	grievance process, which may take up to 30 to 45 days to
35	process. The bill requires DHS to adopt administrative rules

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- 1 and contractually require all Medicaid MCOs to issue a decision
- 2 in response to a member's request for disenrollment for good
- 3 cause within 10 days of the date the member submits the request
- 4 to the MCO utilizing the MCO's grievance process.
- 5 Division V of the bill requires the DHS to develop
- 6 uniform authorization criteria for, and to utilize a request
- 7 for proposals process to procure, a single credentialing
- 8 verification organization to be utilized in credentialing
- 9 and recredentialing providers for the Medicaid managed care
- 10 and fee-for-service payment and delivery systems. The bill
- ll requires DHS to contractually require all Medicaid managed
- 12 care organizations (MCOs) to apply the uniform authorization
- 13 criteria and to accept verified information from the single
- 14 credentialing verification organization procured by the
- 15 state, and to contractually prohibit the MCOs from requiring
- 16 additional credentialing information from a provider in order
- 17 to participate in the Medicaid managed care organization's
- 18 provider network.
- 19 Division VI of the bill relates to the office of long-term
- 20 care ombudsman (OLTCO) and the Medicaid managed care ombudsman
- 21 program (MCOP).
- 22 For fiscal year 2021-2022, the bill appropriates \$300,000
- 23 from the general fund of the state, in addition to any other
- 24 funds appropriated from the general fund of the state to,
- 25 and authorizes 2.50 FTEs in addition to any other full-time
- 26 equivalent (FTE) positions authorized for, the OLTCO for the
- 27 purposes of the MCOP. The funding appropriated and the FTE
- 28 positions authorized under the bill are in addition to any
- 29 other funds appropriated from the general fund of the state and
- 30 actually expended, and any other FTE positions authorized and
- 31 actually filled as of July 1, 2021, for the MCOP.
- The bill requires that any funds appropriated to and any
- 33 full-time equivalent positions authorized for the OLTCO for the
- 34 MCOP for fiscal year 2021-2022 shall be used exclusively for
- 35 the MCOP. The additional FTE positions authorized in the bill

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- 1 for the MCOP shall be filled no later than September 1, 2021.
- 2 The bill requires the OLTCO to include in the MCOP report, on
- 3 a quarterly basis, the disposition of resources for the MCOP
- 4 including expenditures and a full-time equivalent positions
- 5 summary for the prior quarter.